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October 8, 2010

Rene Stephens, Administrator
Bitterroot Home
1411 Falls Avenue East, Suite 703
Twin Falls, ID 83301

Provider #13G022

Dear Ms. Stephens:

On **October 5, 2010**, a complaint survey was conducted at Bitterroot Home. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00004780

Allegation #1: Individuals do not receive treatment and assessment for medical concerns.

Findings #1: An unannounced onsite complaint investigation was conducted from 10/4/10 to 10/5/10. During that time observations, record reviews and interviews were conducted with the following results:

Observations were conducted at the facility and day treatment program on 10/4/10 and 10/5/10 for a cumulative 4 hours and 4 minutes. One individual was noted to stay home from day programming on 10/5/10 due to illness. appeared coherent and showed no overt signs and symptoms of significant medical concerns which were not being addressed. All individuals observed were noted to have good skin integrity.

The facility's investigations and incident and accident reports from 5/8/10 - 10/3/10 were reviewed. None of the incident/accident reports documented concerns with individuals' ongoing medical needs.

Three individuals were selected for review. One individual's record showed he suffered from petichae (round spots that appear on the skin as a result of bleeding

under the skin) and ear infections from a possible environmental allergen. His record documented he received an allergy test to rule out possible environmental allergens. His record further documented he had been seeing a specialist for low blood platelet counts. The record documented the specialist believed he had an immune disorder; however the risks associated with diagnostic testing did not outweigh the benefits. The record documented the individual was being monitored by the facility nurse and his medical providers.

Another individual's medical records documented a seizure disorder and a VP shunt (Ventriculoperitoneal shunting is surgery to relieve increased pressure inside the skull). His record contained a document from {name of clinic} - Neurology, dated 8/31/10, stating "{Individual's} seizures are doing well." and "We will continue decreasing the phenobarbital." The report also recommended a follow up in 8-10 weeks. There was also a nursing note, dated 4/29/10, stating he recently had an EEG which showed no seizure activity.

Another document from {name of clinic} - Internal Medicine, dated 3/2/10, showed the individual had his shunt checked and there was "No headache and no sign of shunt failure or malfunction." Additionally, two nursing notes, dated 8/5/10 and 4/29/10, documented the shunt appeared to be functioning well and he would see the doctor as needed for follow up.

Review of the third individual's medical record documented no major medical concerns.

Nine facility and day program staff were interviewed. All stated they were not aware of any medical conditions going unaddressed.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #2: Individuals do not receive therapy for ongoing OT/PT needs.

Findings #2: An unannounced onsite complaint investigation was conducted from 10/4/10 to 10/5/10. During that time observations, interviews and record reviews were conducted with the following results:
A cumulative total of 4 hours and 4 minutes of observations were made during day shift, swing shift and at the day program. During that time, one individual receiving physical therapy services was noted to independently move his wheelchair using his right hand.

A total of 9 staff were interviewed across day shift, swing shift and the day program. Staff consistently stated that they were not aware of any individuals regressing in their physical skills or other abilities.

Medical records and IPP's for 3 individuals residing at the facility were reviewed with 2 individuals noted to be in need of physical therapy services. One individual's record contained a physical therapy evaluation, dated 2/19/10, stating he was to receive passive range of motion to his left shoulder, elbow and wrist. The report also documented the PT provided him with a pulley kit to allow him to do range of motion with his shoulders. Staff were able to describe the use of the pulley kit and his record confirmed he was receiving the above services. His record also contained a document from {name of clinic} - Physical Medicine and Rehabilitation, dated 8/25/10, which documented a follow up visit for a Botox injection recheck. The document stated "He and his caregivers have noted an improvement in the range of motion at the elbow and shoulder." Additionally, his record also contained a nursing note, dated 8/5/10, documenting there was a plan for a possible tendon release to further increase range of motion.

Another individual's record contained an occupational therapy evaluation, dated 12/16/08, stating he was to participate in range of motion activities. His IPP, dated 10/23/09, documented he had programs in place to address his range of motion needs.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: Restrictions are placed on family members or guardian visitation.

Findings #3: An unannounced onsite complaint investigation was conducted from 10/4/10 to 10/5/10. During that time interviews and record reviews were conducted with the following results:

A total of 6 staff was interviewed across day shift and swing shift. Staff consistently stated the only restriction to visitations they were aware of was an individual's mother being restricted to supervised visits and she was not allowed in the home.

A total of 3 records were reviewed. One individuals' record documented the mother was restricted from the home and all visits were to be supervised. The record also documented the mother was not the legal guardian of the individual and the

guardians had requested the restrictions. The record contained further documentation the mother had visited at least 10 times from 1/12/10 - 9/9/10, which included going out to lunch and going out to dinner/birthday party. Additionally, the record contained the minutes of a meeting, dated 3/5/09, in which the mother, co-guardians, QMRP, Quality Assurance Manager, and the Facility Manager were present. The meeting minutes documented an agreement to limit the visits to 2 visits of 30 minutes each.

Therefore, the allegation was substantiated with no deficient practice identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #4: Staff treat individuals with disrespect.

Findings #4: An unannounced onsite complaint investigation was conducted from 10/4/10 to 10/5/10. During that time observations, record reviews and staff interviews were conducted with the following results:

Observations was conducted at the facility and day treatment program on 10/4/10 and 10/5/10 for a cumulative 4 hours and 4 minutes. Staff were noted to treat all individuals with respect.

Three individuals were selected for in-depth review. Those 3 individuals' records did not contain documentation of staff making inappropriate comments to them at any time.

The facility's investigations and incident and accident reports from 5/8/10 - 10/3/10 were reviewed. No documentation of allegations of abuse, neglect, or mistreatment was found.

Additionally, 9 staff who had worked at the facility and day program were interviewed. None of the staff had witness or had knowledge of individuals being treated with a lack of respect. All of the staff stated if they witnessed individuals being treated without respect they would report it to the house manager or a supervisor. Staff stated that at times they would "slip" and call the individuals names such as "sweetie." However, that was only on occasion.

Therefore, the allegation was unsubstantiated and no deficient practice was identified.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

As none of the allegations were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

JIM TROUTFETTER
Health Facility Surveyor
Non-Long Term Care

NICOLE WISENOR
Co-Supervisor
Non-Long Term Care

JT/srm